

### 3600. INTRODUCTION

This chapter describes the medically needy and the related requirements of determining eligibility. The policies set forth in this chapter related to the medically needy reflect self-implementing amendments contained in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 98-248), amendments contained in the Deficit Reduction Act of 1984 (P.L. 98-369), and the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272).

**3600.1 Changes Due To Welfare Reform.**--The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the AFDC program and replaced it with a block grant program for temporary assistance for needy families (TANF). States may begin their TANF programs between August 22, 1996 and July 1, 1997. This law established a new Medicaid eligibility group for low income families with children which is described in §3301. After the TANF program is in effect in your State, all references to AFDC (or title IV-A) in this chapter are references to AFDC under the AFDC State plan in effect on July 16, 1996. The income standard under the July 16, 1996 AFDC State plan may be increased by any subsequent increases in the consumer price index (CPI) for all urban consumers (all items; U.S. city average) or lowered to a level no lower than the level in the AFDC State plan in effect on May 1, 1988.

**A. Limitation of Federal Financial Participation (FFP).**--If you choose to raise your AFDC income standard for purposes of determining eligibility under the mandatory group of low income families with children (see §3301), the FFP limitation explained in §3624 is raised accordingly. However, if you choose to lower your income standard for that group below the July 16, 1996 level, the FFP limitation remains based on the July 16, 1996 level.

**B. Medically Needy Income Level.**--The medically needy income level (MNIL) may be no higher than the FFP limitation. If you choose to lower your income standard for the mandatory group of low income families with children (see §3301), you may lower the MNIL to a level no lower than the income standard used for the low income families with children group. (If you choose to raise your income standard for the mandatory group of low income families with children, you are not required to raise your MNIL.)

**C. Income and Resource Methodologies.**--Less restrictive income and resource methodologies adopted under §3301 do not carry over to references to AFDC in this chapter. All references to AFDC in this chapter include only the income and resource methodologies under your AFDC State plan in effect on July 16, 1996.

### 3601. BACKGROUND

The "medically needy" option allows States to provide Medicaid to individuals and families who have more income and, in some instances, more countable resources than allowed for Medicaid eligibility under the mandatory or optional categorically needy groups described in §1902(a)(10)(A) of the Social Security Act (the Act). A feature of this option is that an individual or family having income in excess of a State's prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses and establish Medicaid eligibility. This method used for determining eligibility is referred to as spenddown.

Prior to October 1981, States electing to provide Medicaid to the medically needy were required to include the same types of individuals defined by State's or Territories' Medicaid plans as categorically needy (with certain specified exceptions). States were also required to follow financial methodologies and standards used in the cash assistance program, Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income (SSI) for determining eligibility for the medically needy (with certain specified exceptions).

The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) (OBRA) amended §1902(a)(10)(C) of the Act to allow States more flexibility in defining the "medically needy" and permitted States to vary Medicaid services by group. Regulations implementing OBRA permitted States to determine eligibility of medically needy by varying financial requirements used for each medically needy group. It also permitted States to use financial methodologies that were more or less restrictive than the cash assistance programs.

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 98-248) (TEFRA) again amended §1902(a)(10)(C) of the Act. These amendments, were retroactive to the effective date of the OBRA changes. Under the TEFRA amendments, States are required to use a single income and resource standard (i.e., the standards used could not vary by group). The income and resource methodologies of the most closely related cash assistance program are to be used to determine eligibility. Section 1902(a)(10)(C) of the Act was also amended to clarify who States and Territories must include if they elect to provide Medicaid to the medically needy and who may be covered, at their option. These changes were self-implementing.

Section 2373 of the Deficit Reduction Act of 1984 (P.L. 98-861) (DRA) imposes a moratorium on Health and Human Services (HHS) actions arising from States' or Territories' use of certain standards or methodologies in their medically needy programs.

Section 9501 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99-272) amended §1902(e) of the Act effective April 7, 1986 to provide that pregnant women who, while pregnant, applied for and received Medicaid on the date pregnancy ended are eligible for pregnancy-related and postpartum services under the State plan for a 60-day period beginning on the date pregnancy ends.

Sections 1902(a)(10)(C) and 1902(e)(5) of the Act define who States and Territories must include if they provide Medicaid to the medically needy, and establishes financial eligibility requirements. Section 1902(a)(10)(C) and 1905(a) of the Act describes who States may cover under the medically needy option.

Section 1902(a)(17) of the Act sets forth provisions for establishing reasonable income and resource standards. Section 1903(f) of the Act establishes the Federal financial participation (FFP) limit for the income level used to determine eligibility.

### 3610. ELIGIBLE GROUPS

Under §1902(a)(10)(C) of the Act, the medically needy are defined as:

"Any group of individuals described in §1905(a) who are not described in subparagraph (A)."

Therefore, individuals who are described in subparagraph (A) of §1902(a)(10) (which includes both the required categorically needy and the optional categorically needy groups) cannot be medically needy individuals. Whether the State has elected to cover a particular optional categorically needy group has no bearing on the issue of who can be medically needy.

Sections 1902(a)(10)(C) and 1905(a) of the Act provide States and the Territories considerable flexibility to define their medically needy population. However, if a plan includes the medically needy, the individuals described in §1902(a)(10)(C)(ii) of the Act and §232 of P.L. 93-66 must be included. Individuals described in §1905(a) of the Act and §233 of P.L. 93-66 may be included at the option of a State or Territory.

### 3611. REQUIRED GROUPS

3611.1 Individuals Under Age 18 and Pregnant Women.--Section 1902(a)(10)(C)(ii) of the Act requires that the plan include:

A. Individuals under age 18 who are ineligible for Medicaid under a mandatory categorically needy coverage group described in §1902(a)(10)(A)(i) solely because of income and resources (for example, a child who is ineligible for AFDC, SSI, or as a qualified child solely because of income and resources).

B. Pregnant women who are ineligible for Medicaid under the State's title XIX plan under a categorically needy coverage group described in §1902(a)(10)(A) solely because of income and resources. For example, a qualified pregnant woman or a blind or disabled pregnant woman who is ineligible for Medicaid or SSI solely because of income and resources would be classified as medically needy.

#### 3611.2 Newborn Children and Extended Coverage of Pregnant Women

Section 1902(e)(4) and (5) require that the plan include:

A. A child born to a woman eligible for and receiving Medicaid (regardless of the category of assistance; AFDC or SSI-related) on the date her child was born is deemed to have filed an application and been found eligible for Medicaid for a period of 1 year provided:

1. The mother remains eligible under the agency's plan, and
2. The child remains in the same household.

This includes children born to a woman who attains eligibility on the date the child is born (e.g., one who meets spenddown liability on that date). Use AFDC rules at section 45 CFR 233.90(c)(1)(v) or SSI rules at sections 20 CFR 416.1149(a) and 416.1167(a) as appropriate to determine if a child meets the condition of remaining in the household with the mother.

B. Pregnant women who, while pregnant, were eligible for and received Medicaid on the date pregnancy ends; i.e., date of delivery, date of spontaneous abortion or date of Federally funded induced abortion. Such women will continue to be Medicaid eligible for pregnancy-related and postpartum services under the plan for a 60-day period beginning on the date pregnancy ends. Included under this provision are pregnant women who attain eligibility on the date pregnancy ends.

#### 3611.3 Grandfathered Groups

Section 232 of P.L. 93-66 requires that the plan include blind and disabled individuals who:

A. Meet all current requirements for Medicaid eligibility except for the blindness and disability criteria (such individuals must meet the agency's 1973 blindness and disability criteria), and

B. Were eligible as medically needy in December 1973 as blind or disabled, and

C. For each consecutive month since December 1973 continue to meet the December 1973 eligibility criteria.

#### 3612. OPTIONAL ELIGIBLE GROUPS

In addition to the individuals described in §3611, the plan may include any one or more of the following groups of individuals described in §1905(a) of the Act:

A. All financially eligible individuals under age 18, 19, 20 or 21 or, at a State or Territory's option, reasonable classifications of such individuals who are ineligible as categorically needy.

B. Caretaker relatives who are not eligible as categorically needy; i.e., relatives specified in §406(b)(1) with whom a child is living if such child could be classified as a dependent child under part A of title IV.

C. Aged individuals (65 or older) who are ineligible as categorically needy.

D. Blind individuals who are ineligible as categorically needy, but who meet the categorically needy definition of blindness.

E. Disabled individuals who are ineligible as categorically needy, but who meet the categorically needy definition of disability.

### 3613. CRITERIA FOR DETERMINING CATEGORICALLY NEEDY AND MEDICALLY NEEDY

The following criteria are used to determine whether an individual or family is covered for Medicaid as categorically needy or medically needy.

3613.1 General Requirements.--Any individual or family who meets the criteria of eligibility as a categorically needy individual described in §1902(a)(10)(A) of the Act is not medically needy. Whether the State has elected to cover a particular coverage group has no bearing on the issue of who is categorically needy and who is medically needy.

The definitions of mandatory and optional categorically needy groups generally require that individuals and families meet the financial requirements of the AFDC and SSI programs. The test of whether an individual or family is medically needy or categorically needy is based on a comparison of countable income to the AFDC or SSI income standard, whichever is appropriate. If income is equal to or below those standards the individual or family is categorically needy. Exceptions to this rule are described in §3613.2.

### 3613.2 Exceptions

A. State Supplements.--If a State has established an income level higher than the SSI program in order to provide optional State supplements under §1902(a)(10)(A)(ii)(IV), the optional State supplement standard must be used for determining who is categorically needy as appropriate. For example, if a State supplement is provided to all aged, blind and disabled, the State supplement standard must be used for all SSI-related individuals. However, if a State supplement is only provided to individuals in domiciliary care, the State supplement standard would only be used for individuals in that living arrangement. If there is no optional State supplement program, the general requirements are used to determine who is categorically needy as the income level for such individuals is zero.

B. Special Income Level.--If a State has established a special income level for institutionalized individuals under §1902(a)(10)(A)(ii)(V), that income level(s) must be used for determining if institutionalized individuals are categorically needy. If there is no special income level, the general requirements or the income level for State supplement recipients are used to determine who is categorically needy.

3613.3 States Which Use More Restrictive Requirements of Eligibility for Aged, Blind and Disabled Than SSI.--45 CFR 435.330 sets forth specific requirements for distinguishing categorically needy aged, blind and disabled individuals from the medically needy in these States:

A. Consider as categorically needy those individuals who meet the State's categorically needy financial standards (income and resources) after deducting from the individual's income his SSI payment, any optional State supplement that meets the conditions of 42 CFR 435.230 and incurred medical expenses and:

1. Who, before his incurred medical expenses are deducted from income, meet the income and resource requirements for the SSI or a State supplement that meets the requirements of 42 CFR 435.230; or

2. Would be eligible for SSI or a State supplement that meets the requirements of 42 CFR 435.230 with the OASDI cost-of-living disregards applied under 42 CFR 435.134 and 435.135.

When determining whether an individual meets the financial requirements for the SSI program, no additional development is needed when the individual receives an SSI payment. If he is not receiving payment, compare countable income to the SSI Federal Benefit Rate (FBR) that would be used if the individual were receiving SSI benefits. The FBR used is that which would be used under the SSI program based on an individual or couple's living arrangement. Countable income is determined in accordance with SSI program policies.

In order to use a State supplement income standard for this purpose, a State must have elected to use such a standard under 42 CFR 435.121 and payments made under the State supplement program must meet the requirements of 42 CFR 435.230(b)(2).

The disregards of OASDI cost-of-living increase described in 42 CFR 435.134 and 435.135 must be used to determine whether an individual is categorically needy or medically needy. (The disregard described at 42 CFR 435.135 is only used in determining Medicaid eligibility for the categorically needy in States using more restrictive requirements for aged, blind and disabled if the State has elected this disregard in its plan. This disregard is not used to determine eligibility for the medically needy.)

B. Consider all other aged, blind and disabled as medically needy.

The following examples reflect how the criteria above are applied to specific case situations:

EXAMPLE 1:

An aged individual applies for Medicaid. He has countable resources below the State's categorically needy resource standard. His countable income is below the appropriate SSI FBR and his countable resources are below the SSI resource standard. However, he does not incur medical expenses in an amount that brings his income down to an amount equal or below the State's categorically needy income level. In this instance, the individual's eligibility for Medicaid must be considered against the State's medically needy criteria.

It should be noted that if the State's medically needy income level is lower than the State's categorically needy income level, the individual is not Medicaid eligible.

EXAMPLE 2:

A disabled individual applies for Medicaid. He is in a skilled nursing facility. His countable income after appropriate deductions is below the State's categorically needy income level. His resources are also below the categorically needy resource standard and he is receiving an SSI payment. In this instance, the individual is categorically needy.

3620. FINANCIAL ELIGIBILITY

The financial determination of eligibility takes into account the need, income and resources of members of the budgetary unit and may include consideration of the income and resources of individuals outside the unit. Section 1902(a)(10)(C)(i) of the Act sets forth the specific financial requirements of eligibility. Determination of financial eligibility is based on:

- A. Comparison of income to a single income standard which does not exceed the FFP limit established at §1903(f).
- B. Comparison of resources to a single resource standard.
- C. Methods for treatment of income and resources that are the same as the most closely related cash assistance program (AFDC or SSI) unless more liberal or more restrictive methods are used under the provisions described in §§3620.1 and/or 3700.
- D. Deduction from income of incurred medical and remedial care expenses.

3620.1 States Employing More Restrictive Requirements of Eligibility for the Aged, Blind and Disabled.--States which have elected not to cover all recipients of SSI for Medicaid, but who employ more restrictive requirements of eligibility for the aged, blind and disabled are exempted from certain of the provisions outlined in §3620.

Section §1902(a)(10)(C)(i) of the Act requires a single standard and use of the same methodologies as the most closely related cash assistance programs. Section 1902(f) permits you to use requirements of eligibility for the aged, blind and disabled that are not more restrictive than you employed on January 1, 1972 but no more liberal than requirements employed under the SSI program. Therefore, if you elect coverage under §1902(f) you may use a more restrictive income standard and resource standard for aged, blind and disabled individuals than used for medically needy families with children. You may also employ more restrictive income and resource methodologies than employed under the SSI program for aged, blind and disabled individuals.

Such States may also have more liberal income and resource policies for the medically needy approved under the Moratorium provision discussed in §3700.

#### 3621. SINGLE INCOME AND RESOURCE STANDARD

The plan must reflect a single income standard and resource standard which applies to the entire group of medically needy recipients. Those standards may differ between required groups and optional groups, but within each group the income and resource standard must be uniform. For example, the plan cannot reflect an income and/or resource standard for individuals under age 18 and a different standard for pregnant women or an income and/or resource standard for noninstitutionalized individuals and a different standard for institutionalized individuals. The plan can, however, reflect variations in the single income standard between urban and rural areas based on differences in shelter costs.

The standard used to determine eligibility for families of varying sizes must be described in the plan. You do not have to increase the standard based on family size, but it must describe what standard is used. The plan may, however, provide for incremental increases, but standards cannot diminish based on an increase in family size. The standard used must be reasonable and within the Federal Financial Participation (FFP) limitations set forth at §1903(f) of the Act.

The income standard is generally referred to as the medically needy income level (MNIL).

#### 3622. COST OF LIVING VARIATIONS

Section 1902(a)(17) of the Act permits different income standards for urban and rural areas. This method permits States and Territories to recognize differences in the major variable consumption item of shelter and appropriate special need items without unduly complicated administrative procedures. Variations may not be based on considerations such as whether persons own their own homes or rent, nor be interpreted to only recognize shelter costs on "as paid" or "as paid to a maximum" basis. Variation may be based on a cost of living index.

States and Territories are encouraged to limit such variables to two or three differentials as recognized in the AFDC plan. Any variables must be supported by data reflecting cost-of-living differentials within a State or Territory.

## 3623. DEFINING REASONABLE STANDARDS

Income and resources standards for the medically needy which are presumed to be reasonable and which do not require HCFA review and approval are described in §§3623.1 -3623.3. Standards that do require HCFA review and approval are addressed in §3623.4.

3623.1 SSI States.--The following standards are presumed to be reasonable:

A. Medically Needy Income Level (MNIL).--

1. The standard must be equal to the highest need or payment standard used to determine eligibility in the cash programs related to the medically needy coverage group(s) including a standard used to determine Medicaid eligibility for a recipient of an optional State supplement. An optional State supplement standard may only be used if the standard is applied to at least all the aged, all the blind, or all the disabled, and you cover such individuals under §42 CFR 435.230.

2. The standard must be equal to the maximum standard allowed for purposes of FFP.

B. Resource Standard.--This standard must be equal to the highest standard used to determine eligibility in the most closely related cash assistance program.

3623.2 States Using More Restrictive Requirements for Aged, Blind and Disabled.--The following standards are presumed to be reasonable:

A. Medically Needy Income Level.--

1. If you had no medically needy program on January 1, 1972, you may use a standard presumed to be reasonable under §3623.1 (SSI States).

2. If you had a medically needy program on January 1, 1972, you may use a standard presumed to be a reasonable standard in SSI States or may use any lower standard for aged, blind and disabled. The standard must be at least equal to the medically needy standard for aged, blind and disabled under your plan on January 1, 1972. For AFDC related individuals you must use one of the standards presumed to be reasonable in SSI States.

B. Resource Standard.--

1. If you had no medically needy program on January 1, 1972, you may use any standard presumed to be reasonable under §3623.1 (SSI States).

2. If you had a medically needy program on January 1, 1972, you may use a standard presumed to be reasonable for SSI States or may use any lower standard for aged, blind and disabled that is at least equal to the medically needy standard for aged, blind and disabled under your plan on January 1, 1972. For AFDC related individuals, use a standard presumed to be reasonable in SSI States .

3623.3 The Territories.--The following standards are presumed to be reasonable:

A. Medically Needy Income Level (MNIL).--

1. A standard must be at least equal to the highest income standard used on or after January 1, 1966, to determine eligibility for the following programs related to the medically needy groups:

- o Old Age Assistance (OAA),
- o Aid to Families with Dependent Children (AFDC),
- o Aid to the Blind (AB), and
- o Aid to the Aged, Blind and Disabled (AABD).

2. The standard must be equal to the maximum standard allowed for purposes of FFP.

B. Resource Standard.--This standard must be at least equal to the highest standard used on or after January 1, 1966, to determine eligibility for OAA, AFDC, AB, APTD, and AABD programs that are related to the medically needy groups.

3623.4 Other Standards That May be Determined Reasonable.--The standard(s) of any one of the most closely related cash assistance programs may be used as the medically needy income and resource standards, including the lower of the two standards. However, the standards must be:

- o described in the State title XIX plan,
- o the reasonableness of the standards adequately justified, and
- o reviewed and approved by HCFA.

3624. FEDERAL FINANCIAL PARTICIPATION (FFP) LIMITATION

Section 1903(f) of the Act establishes the FFP limitation on income and is implemented through regulations at 42 CFR 435.1007. FFP is available in expenditures for services provided to medically needy recipients whose annual income after deductions specified in 42 CFR 436.832 (a) and (c) and 436.832 does not exceed the following amounts, rounded to the next higher multiple of \$100. These include:

A. for families of two or more, 133 1/3 percent of the maximum payment that could be made to the same size family under the AFDC plan. If the State's AFDC plan specifies a maximum family size beyond which there is no increase in benefits, MNILs for families exceeding that maximum will be determined by adding an amount for each additional family member beyond the maximum. The amounts must be reasonably related to the amounts by which the AFDC plan increases benefits per additional family member up to the maximum size.

B. for individuals, 133 1/3 percent of an amount reasonably related to the highest money payment which would ordinarily be made under the AFDC plan to a family of two without income and resources.

There is no specific statutory FFP limitation on the resource level used. However, that level must be reasonable.

#### 3625. FINANCIAL METHODOLOGIES

Section 1902(a)(10)(C)(i) requires use of the same methodologies for determining income and resource eligibility that are used in the most closely related cash assistance programs unless otherwise specified in §3620. Chapters III and IV provide an overview of AFDC and SSI policies and describes how certain policies are used to determine eligibility for the medically needy. These chapters are to be used in conjunction with your AFDC plan and implementing policies, Part 5 of SSA's Program Operations Manual (POMS) and Appeals Council decisions rendered relative to SSI program policies.

Methodologies include, but are not limited to the following:

- o Definitions of income and resources,
- o Exclusions or disregards of income and resources,
- o Composition and number of persons that are included in the budgetary unit (including AFDC standard filing unit provision),
- o Deeming of income from spouses and parents,
- o Treatment of regular and periodic income,
- o Ownership of income and resources, and

Methodologies do not include budget periods.

Income and resources remaining after the exclusion and disregards of income and resources is referred to as "countable" income and resources.

#### 3626. INCOME ELIGIBILITY

An individual or family is income eligible when countable income is equal to or lower than the MNIL for the budget period or when countable income after deduction of specified medical and remedial care expenses is equal to or below the MNIL. The practical application of this rule is to compare countable income to the MNIL for the budget period and deduct incurred medical and remedial care expenses from income in excess of the MNIL. This process is referred to as spenddown. (See 42 CFR 435.831 and 436.831.)

### 3627. BUDGET PERIODS

Use budget periods of not more than 6 months to compute income (42 CFR 435.831 and 42 CFR 436.831). You can use an MNIL that is based on a monthly maintenance need or one that is based on a maintenance need for up to a 6-month period (or, in the case of the three month retroactive period under 42 CFR 435.914 a monthly maintenance need or a maintenance need for up to a 3-month period). Income used to determine eligibility for the budget period is countable income based on the methodologies of the most closely related cash assistance program. Averaging or prorating of income over a longer period is allowed if required by cash assistance program policies; e.g., AFDC policy for counting lump sum non-recurring income.

**3627.1 Multiple Budget Periods**--You may use multiple budget periods provided that the budget periods do not exceed 6 months.

For example, you may choose to apply a 6 month budget period to all medically needy individuals, or use one budget period for institutionalized individuals in long term care facilities (e.g., 1 month), and another for noninstitutionalized individuals. (If you elect a different budget period for institutionalized individuals, this budget period is effective no earlier than the month that begins a consecutive 30-day period of institutionalization. A third option would be to use two different budget periods for noninstitutionalized individuals. If you choose this third option, you must give each noninstitutionalized individual the choice of which budget period is to be applied. You may not selectively provide this choice (e.g., only to individuals receiving a particular type(s) of service).

Each individual or family is provided with an election of the budget period (at the beginning of the budget period). The choice of budget period may be implemented in one of the following ways:

- o The individual or family would be required to use that budget period for the duration of the period.
- o The individual or family is allowed to change this election within the period prior to certification of eligibility.

**EXCEPTION:**--When a budgetary unit encompasses persons in more than one medically needy group, the same budget period must be used for all members of the budgetary unit; e.g., a caretaker who is covered under optional coverage of medically needy is a member of the budgetary unit with his/her child under age 18.

### 3627.2 Reserved

**3627.3 Individuals and Families With Income Below the MNIL**--A significant number of cases, primarily AFDC related, have only regular recurring income that is below the MNIL. They do not have to spend down to become income eligible. Such cases may be maintained in the same manner as categorically needy cases; however, effective the month that income exceeds the MNIL or the first month following the timely notification period, the case must be treated as all other medically needy cases. Eligibility must then be based on the budget period established for the specific medically needy group. If you elect to employ a monthly budget period, however, you must take into account increases in income the month the change occurs unless the projected excess income has

been incurred and a Medicaid card has already been issued for that month and a change in circumstances occurs too late in the month to provide "timely" notice under 42 CFR 435.919 prior to suspending Medicaid benefits. Such agencies are committed to determining eligibility on a monthly basis, therefore, eligibility is always determined monthly and takes into account individual/family's circumstances in that month.

3627.4 Effecting Changes in Circumstances Within a Budget Period.--When a change in circumstances occurs within a multi-month budget period, the agency must use the following methods for redetermining eligibility:

- o Shorten the budget period when the only eligible individual dies or becomes ineligible before the end of the budget period.
- o In other instances, may shorten the current budget period and begin a new budget period, or
- o Recalculate income eligibility for the current budget period.

Following are examples of the application of the three methods.

Method A--Example

The agency or individual has elected a 3-month budget period. Income eligibility is based on income an aged individual is expected to have during the 3-month period. The individual dies in the second month of the budget period. In this instance income eligibility would be redetermined based on a 2-month budget period.

Method B--Example

The agency or individual has elected a 3-month budget period. Income eligibility is based on the projection of income an AFDC-related family is expected to have during the 3-month period and compared to an MNIL for the number of people in the budgetary unit. During the second month of the budgetary period, a member of the budgetary unit moves out of the home.

This change in circumstance could result in an increase or decrease in family income. Using method B, the agency would redetermine eligibility by computing income based on a 2-month period taking into account the members of the unit living in the home for that period and compute a new 3-month budget period for the remaining members of the budgetary unit.

If Medicaid had already been certified for the current budget period and the family's income liability increases when the member of the family moves out of the home, timely notice is required. Therefore, the agency may not be able to effectuate a change in the case until the end of the 3-month budget period. If Medicaid had already been certified and the income liability decreased, an earlier Medicaid eligibility effective date may need to be entered into the Medicaid file.

#### Method C--Example

The agency or individual elects a 6-month budget period. Income eligibility is based on the projection of income an AFDC-related family is expected to have during the 6-month period. During the second month of the 6-month period, the family receives an increase in unearned income and a member of the budgetary unit moves out of the household.

Using method C, recalculate the income computation using the changed circumstances (i.e., standards and income) for each month of the 6-month period.

If Medicaid has already been certified for the current budget period and there is an increase in income liability, provide timely notice before Medicaid benefits are suspended. The suspension of benefits remains in effect through the end of the budgetary period or until the family spends down the additional liability, whichever is earlier. If Medicaid had already been certified and the net effect of the two changes in circumstances decreased the family's liability, an earlier Medicaid eligibility effective date may need to be entered into the Medicaid file.

#### 3628. DEDUCTION OF INCURRED MEDICAL AND REMEDIAL CARE EXPENSES (SPENDDOWN)

The following definitions are used for purposes of this section.

Financially Responsible Relative--A spouse or parent (including a stepparent who is legally liable for support of stepchildren under a State law of general applicability) whose income is actually used in determining eligibility.

Incurred Expenses--Expenses for medical or remedial services:

- o recognized under State law,
- o rendered to an individual, family, or financially responsible relative, and
- o for which the individual is liable in the current accounting period or was liable in the 3-month retroactive period described in 42 CFR 435.914.

An expense as described above is an incurred expense from the beginning of the accounting period in which the liability arises until the end of the accounting period in which the liability is satisfied. The expense is deductible from income in any accounting period in which it meets the definition of an incurred expense but only to the extent that the amount has not been deducted previously. (See §3628.1.)

Liabe Third Party--Any individual, entity or program that is or may be liable to pay all or part of the cost of medical or remedial treatment for injury, disease, or disability of an applicant or recipient of Medicaid.

NOTE: There is no Federal financial participation (FFP) in expenses used to reduce spenddown liability.

Projected Expenses--Expenses for services that have not yet been incurred but are reasonably expected to be.

Spenddown Liability--Amounts by which countable income exceeds the MNIL for the budget period.

State or Territorial Public Program--A program that is operated (i.e., administratively controlled) by a State or territory (including a political subdivision thereof).

State or Territorially-Financed Program--A State or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:

- o appropriated by the State or territory directly to the administering agency, or
- o transferred from another State or territorial public agency to the administering agency.

When countable income exceeds the MNIL for the budget period, deduct from that income certain medical and remedial care expenses incurred by an individual, family or financially responsible relative that are not subject to payment by a third party unless the third party is a public program of a State (or territory) or political subdivision of a State (or territory). Deduct incurred medical and remedial care expenses paid by a public program (other than a Medicaid program) of a State (or territory). Once countable income is reduced (by applying these deductions) to an amount equal to the MNIL, the individual or family is income eligible.

Take reasonable measures to determine the legal liability of third parties to pay for incurred expenses. However, do not forestall an eligibility determination simply because third party liability cannot be ascertained or payment by the third party has not been received. 42 CFR 435.911 prescribes a time period for reaching decisions on Medicaid eligibility, i.e., 60 days for applicants who apply on the basis of disability and 45 days for all others. It establishes a time limit for receipt of third party payment or verification of third party intent to pay in order to determine deductible expenses under spenddown. Efforts to determine the liability of a third party must continue through the last day of this period.

3628.1 Expenses That Must Be Deducted.--Deduct from countable income the medical and remedial care expenses listed below that are not subject to payment by a third party. (Such deductions are allowable even if the expenses are paid by a public program (other than the Medicaid program) of a State or territory if the program is financed by the State or territory.)

- o Insurance premiums (including Medicare), deductibles or coinsurance charges including enrollment fees, copayments or deductibles imposed under 42 CFR 447.51 or 447.53 subject to any reasonable limits you choose to impose;

- o Necessary medical and remedial services recognized under State law but not included in your plan, subject to reasonable limits;

- o Necessary medical and remedial services included in your plan (subject to any reasonable limits you choose to impose). For example, you may limit types of services such as cosmetic or podiatrist's services. You are encouraged to restrict exclusions to items of care that can be determined, based on medical advice, not to be essential or necessary;

- o Expenses incurred during the month of application and the 3 preceding months described at 42 CFR 435.914 are deducted unless such expenses have been paid by or are subject to payment by a legally liable third party as described in §3628. Expenses incurred by the individual, family or legally responsible relative and paid by the individual, family or legally responsible relative are deducted; and

- o Current payments or unpaid balance on old bills incurred outside the current prospective and 3-month retroactive periods not previously deducted in any budget period are also deducted.

3628.2 Optional Deductions and Limitations on Incurred Medical Expenses.--Optional limits placed on insurance premiums, deductibles or coinsurance charges and necessary medical and remedial care expenses included in your plan must be reasonable. Following are examples of limits that are not reasonable:

- o An accumulative dollar limit for all services subject to reasonable limits. For example, a \$600 limit; and
- o A limit on services included in your plan that is the same as a limit already included in your plan. For example, if your plan limits drugs to three prescriptions per month, you may not impose a combined limit of three prescriptions as covered and noncovered incurred expenses.

Although no accumulative dollar limit may be imposed, dollar limits may be imposed on individual services. Additionally, you may impose limits on the number of visits or items of covered services provided they exceed limits included in your plan.

3628.3 Projection of Expenses.--Do not project medical and remedial care expenses that are not for institutional care services (excluding acute care facility services). For example, insurance premiums are not an institutional service, therefore, such expenses cannot be projected. Nor may you deduct expenses that are included in a prepaid package of services prior to the date the services are rendered (e.g., charges for prenatal care and delivery services and orthodontia).

3628.4 Projection of Institutional Care Expenses.--The agency has the option of projecting institutional care expenses (except for expenses for services rendered in an acute care facility). The amount of the projected expenses is based on the private pay rate or a combination of actual incurred institutional expenses and projected expenses.

Election of the option to project institutional care expenses does not preclude deduction of actually incurred expenses and in some instances requires the use of a combination of actually incurred expenses and projected expenses. Those circumstances are:

- o When the projected institutional care expense is less than the individual's spenddown liability for the budget period; and
- o When there is current liability for bills from a period prior to the current retroactive and prospective budget periods. A bill written off as a bad debt is not a current liability.

3628.5 Date of Eligibility.--The total of actually incurred expenses and/or projected expenses are added together and deducted from the spenddown liability for the budget period. If the total of the projected expenses does not exceed the spenddown liability for the budget period, the individual must incur additional expenses in order to be income eligible. Thus, depending on individual circumstances and your election of full or partial month coverage under 42 CFR 435.914, an individual could be eligible on the first day of the budget period or sometime during the budget period. If you elect full month coverage, eligibility begins on the first day of the month in which spenddown liability is met. (You are reminded, however, that although the effective date of eligibility begins on the first day of a month FFP is not available for expenses used to reduce spenddown liability.) If you elect partial month coverage, eligibility begins on the day all conditions of eligibility (including spenddown) are met.

Following are examples that illustrate projection of expenses and the effective date of eligibility.

**Example 1:** The individual is in the institution as of the first day of the month. His monthly spenddown liability is \$2000. The projected private rate is \$1,800 per month (\$60 per day). Since the projected institutional expense is \$200 less than the spenddown liability of \$2000, the individual is not eligible based on his projected institutional expense. However, on the 3rd day of a prosthesis costing \$200 is purchased. Thus on the 3rd of the month the combination of projected and actually incurred expenses equal the spenddown liability and the individual is income eligible.

**Example 2:** The individual enters the institution on the 16th of the month. The monthly spenddown liability is \$500. The individual has incurred \$600 in other medical expenses prior to the month of application which remain the individual's current liability. Because the individual has \$600 of other medical expenses, the spenddown is met on the first day of the monthly budget period (prior to the first day of institutionalization).

**3628.6 Application of Post-Eligibility Rules When Projection of Institutional Care Expenses Is Used.--**§§42 CFR 435.733, 435.832 and 436.832 specify how an eligible individual's income is applied to the cost of institutional care. Following are examples of how eligibility rules and post-eligibility rules interface.

**Example 1:** An individual's monthly income is \$925. The monthly private rate is \$1,400. The monthly spenddown liability is \$600. The individual is in the institution as of the first day of the month. Since the projected monthly institutional expense (\$1,400) exceeds the monthly spenddown liability (\$600), the individual is considered eligible on the first of the month. Thus, the post-eligibility treatment of income rules apply. At least \$25 per month of the individual's income is protected for personal needs. Thus, the State must reduce its payment to the institution by \$900 (\$925 - \$25) and the individual would apply \$900 of his income toward the cost of care. The Medicaid rate is \$1,200, therefore, the State would pay the institution \$300 (\$1,200 - \$900).

**Example 2:** An individual's monthly income is \$1,820. The monthly private pay rate is \$1,200 (\$40 per day). The monthly spenddown liability is \$1,500. The individual is in the institution as of the first day of the month and the State projects institutional expenses at the private pay rate.

Since projected monthly expenses as of the first day of the month are not sufficient to meet the spenddown liability (\$1,500), the individual is not eligible. However, after remaining in the institution for 15 days the individual has actually incurred expenses of \$900. The projected institutional expenses for the remaining days in the month are \$600 (\$40 x 15 days). Thus, as of the 15th day of the month, the individual is eligible and the rules of post-eligibility treatment of income apply.

Under the post-eligibility rules, \$25 per month of the individual's income is protected for personal needs. Prorated for the 15 days remaining in the month, the Medicaid rate is \$450, the individual's income is \$910, and the protected income for personal needs is \$12.50. Therefore, the State must reduce its payment at the Medicaid rate to the

institution by \$897.50 (\$910 - \$12.50). The individual would apply this amount toward the cost of care up to the Medicaid rate \$450 for the 15 day period and the State would pay \$0 toward the cost of care. The individual would retain \$320 of his \$1,820 income each month.

3628.7 Order of Deduction.--Deduct incurred expenses in the following order:

1. Insurance premiums, deductibles or coinsurance charges including enrollment fees, copayments or deductibles imposed under §§42 CFR 447.51 or 447.53;
2. Necessary medical and remedial services that are recognized under State law but not included in the Medicaid plan;
3. Necessary medical and remedial services that exceed Medicaid plan limitations on amount, duration and scope imposed by the agency;
4. Necessary medical and remedial services that are included in the agency's Medicaid plan, within the agency's limitations on amount, duration and scope of services.

### 3630. RESOURCE ELIGIBILITY

An individual or family is eligible based on resources if countable resources at a preestablished time are below the single resource standard established by the agency for the medically needy. The methodologies of the most closely related cash assistance program (AFDC or SSI) are used to determine what resources are counted in their assigned monetary value for determining eligibility.

Individuals or families may not spenddown resources and become Medicaid eligible immediately when the resource standard is exceeded. This does not, however, preclude the individual or family from reducing resources to an amount below the resource standard and attaining Medicaid eligibility at the preestablished time (as defined under the most closely related cash assistance program) in a subsequent month.

3630.1 Distinguishing Income from Resources in Multi-Month Budget Periods.--The cash assistance programs use a monthly budget period for determining income eligibility. Generally, income retained after the month of receipt is considered to be a resource. As the agency may use a budget period of more than one month for the medically needy, a strict application of the cash assistance policy in this instance results in counting income as both "income" and a "resource" for the same budget period. In order to be consistent with the title XIX income requirements for the medically needy, agencies which use multi-month budget periods must consider as a resource all income retained beyond the budget period in which it was received.

## 3640. MORATORIUM

The moratorium under §2372(c) of the Deficit Reduction Act (DRA) of 1984 prohibits the Secretary from taking certain adverse actions against States because they are applying more liberal financial eligibility standards and methods than specified in §1902(a)(10) of the Social Security Act (the Act).

During the moratorium period (see 3640.1) the Secretary's actions are limited in the following areas:

- o No disallowance, compliance, penalty, or other regulatory action will be taken against States (including States using more restrictive eligibility requirements for aged, blind and disabled) because a plan (or its operation) employs financial eligibility standards and methods the Secretary finds to be more liberal than required under §1902(a)(10)(A)(ii)(IV), (V), or (VI) or §1902(a)(10)(C)(i)(III) of the Act. These sections of the Act pertain to optional categorically needy eligibility groups who are institutionalized, receiving optional State supplementary payments or receiving home and community-based waiver services and the medically needy. (See §3640.3.)

For purposes of this provision "other regulatory action" encompasses the Quality Control (QC) interim adjustment in FFP prior to taking a disallowance after August 18, 1987. It does not include adjustments made to withholdings for previous quarters. "Other regulatory actions" does not include disapproval of moratorium plan amendments as part of the official State plan. The moratorium was not intended to confer on States an unlimited right to use more liberal criteria (which would result if the moratorium required the approval of State plan amendments), but to permit States, without fiscal penalties, to use more liberal eligibility criteria during a period in which Congress considers the issue of whether Medicaid rules should be tied to the eligibility rules of the cash programs.

- o The Secretary must interpret §1902(a)(10)(A)(ii) and §1902(a)(10)(C)(i)(III) to exclude (consistent with procedures in effect on October 1, 1981) former home property institutionalized individuals are attempting to sell. (See §3640.5.)

3640.1 Moratorium Period.--The period extends from October 1, 1981 until February 17, 1989, (or March 1, 1989 in States which provide full month coverage) 18 months after the date the Secretary submitted to the Congress a report on the use of cash assistance standards and methods for eligibility groups which do not receive cash assistance. (The Secretary submitted the report to the Congress on August 17, 1987.)

3640.2 Description of Moratorium State Plan Policies.--For purposes of protection under the moratorium, plan policies include:

- o Moratorium protected policies delineated in a State plan preprint amendment. Policies are protected regardless of whether plan amendments containing such policies were submitted before or after enactment of the clarified moratorium provision (August 19, 1987) or whether the amendments were approved, disapproved, acted upon or not acted upon by the Secretary.

- o Moratorium protected policies delineated in your Medicaid operations or program manual during the moratorium period.

If a protected policy was delineated in your operations or program manual (including policies deleted from a State's preprint under compulsion by HCFA), the policy or standard is considered to be included in the State's plan during the moratorium period and is effective with the effective date of the manual issuance and will terminate upon withdrawal by you or upon expiration of the moratorium.

**3640.3 Description of Groups Included.**--Following are the eligibility groups for which States may employ more liberal financial policies than those required under §1902(a)(10) unless application of more liberal policies violates other statutory provisions.

- o Persons receiving an OSS (see §1902(a)(10)(A)(ii)(IV));
- o Persons in medical or remedial care institutions who:
  - are eligible for, but are not receiving AFDC, SSI, an OSS, or benefits under OAA, AB, APTD, or AABD, or
  - if not in an institution would be eligible to receive AFDC, SSI, an OSS or benefits under OAA, AB, APTD, AABD, (see §1902(a)(10)(A)(ii)(V));
- o Persons in medical or remedial care institutions who are eligible under States' special income levels (see §1902(a)(10)(A)(ii)(V));
- o Persons receiving services under a home and community-based waiver (see §1902(a)(10)(A)(ii)(VI)); or
- o The medically needy (see §1902(a)(10)(C)).

Except as otherwise specified, §1902(a)(10) of the Act requires that cash assistance financial requirements or methods be used to determine eligibility for these eligibility groups. Therefore, you may not alter the statutory criteria which define eligibility for membership in the groups covered by the moratorium, except by using the more liberal policies specified in §3640.4. Thus, for example, you may not employ a higher resource level than the appropriate State plan level or SSI level for determining membership of the §1902(a)(10)(A)(ii)(V) group. This is because the statute specifies that membership in this group is limited to individuals who meet those resource requirements and because the moratorium was not intended to permit variation in the ultimate resource eligibility levels for the protected groups.

**3640.4 Use of More Liberal Policies.**--More liberal policies are limited to income and resource standards and methods and cannot result in rendering current Medicaid eligibles ineligible nor result in income exceeding FFP limits. Methods protected under the moratorium apply only to financial eligibility requirements used to determine eligibility

for cash assistance. They do not include categorical or other nonfinancial requirements for determining Medicaid eligibility. Nor do they include Medicaid policies which have no counterpart in the cash assistance programs, i.e., spenddown policy and post-eligibility treatment of income. This is because the moratorium addresses the problem of the use of cash assistance rules in Medicaid, rather than policies that only apply to Medicaid.

A. More Liberal Standards.--Standards for purposes of the moratorium are standards which are part of the cash assistance program's methods of determining eligibility. You are not exempt from using overall resource standards required under §1902(a)(10)(A)(ii) or §1902(a)(10)(C)(i)(III) or FFP income limits at §1903(f), nor are you exempt from the single standard requirement in §1902(a)(10)(C)(i)(III) insofar as it requires you to use uniform medically needy income and resource standards for a specific family size or composition for all medically needy groups covered under your plan. (See §§3620 - 3621.)

Following are examples of standards which you may exceed (provided use of more liberal standards does not result in rendering Medicaid eligibles ineligible or result in income exceeding FFP limits):

- o \$6,000/6 percent rule for exempting income producing property (SSI);
- o limits on household goods and personal effects;
- o limits on numbers and values of automobiles;
- o limits on burial funds (SSI);
- o standard for valuing in-kind support and maintenance;
- o standards used in deeming.

There are FFP limits for OSS recipients, institutionalized individuals eligible under a special income level and for the medically needy. Therefore, do not use income levels that exceed the limits set in §1903(f).

Persons described in §1902(a)(10)(A)(ii)(VI) must be eligible to receive Medicaid in an institutional setting in order to be eligible for home and community-based waiver services, therefore, you cannot use more liberal income and resource criteria than that used to determine eligibility for the institutionalized. However, should you (under the moratorium) employ a more liberal resource standard for the institutionalized the more liberal resource standard would apply to any groups receiving home and community-based waiver services for which you also elect to apply institutional eligibility rules.

B. More Liberal Methods.--Following are examples of cash program methods that are covered by the moratorium and for which more liberal methods may be applied under the moratorium (provided application of such methods does not result in rendering current Medicaid eligibles ineligible or in exceeding FFP limits).

- o Deeming policies which should include use of institutional deeming rules for categorically needy and medically needy persons receiving services under a home and community-based waiver;
- o Exclusions of resources,
  - First day of the month resource rule,
  - Income producing property exclusions, especially real estate (including contracts for deed),
  - Automobile exclusions,
  - Burial plots (e.g., for use by someone other than a recipient or the immediate family),
  - Household goods and personal effects, and
  - Equity in nonhome property;
- o Community property rules; and
- o Income disregards.

As in the case of income and resource standards, there are groups for which more liberal income methods cannot be employed because FFP is limited to prescribed income levels established under sections of the Medicaid statute other than §1902(a)(10).

Additional disregards of income for institutionalized individuals under a special income level or OSS recipients that would result in gross income exceeding the FFP limit established under §1903(f) are not within the scope of the moratorium.

Additional disregards are permitted for the medically needy, but only to the extent that income (after statutory deductions described in 42 CFR 435.831) is below the FFP limit for the medically needy established in §1903(f). Therefore, only States which set their MNIL lower than the FFP limit can apply more liberal income disregards. For example, if your FFP limit is \$400 and your MNIL is \$375, you may disregard an additional \$25 when an individual's income (after the deduction of appropriate AFDC or SSI income disregards and incurred medical and remedial care expenses) is below \$400.

Persons described in §1902(a)(10)(A)(ii)(VI) must be eligible to receive Medicaid in an institutional setting in order to be eligible to receive home and community-based waiver services, therefore, you cannot use more liberal income and resource criteria than that used to determine eligibility for the institutionalized. However, should you (under the

moratorium) employ a more liberal income and/or resource method for institutionalized individuals the more liberal policies would apply to any groups receiving home and community-based waiver services for which you also elect to apply institutional eligibility rules.

**3640.5 Counting Home Property for Sale by Institutionalized Individuals.**--In accordance with October 1, 1981 procedures SSI States must exclude the value of former home property institutionalized individuals are making a reasonable effort to sell at current market value. Home property is only counted in determining eligibility when there is no dependent relative residing in the home and it has been established that the individual does not intend to return home.

In accordance with §1902(f) of the Act, if you employ more restrictive requirements of eligibility for aged, blind, and disabled you may employ a procedure that is more restrictive than used in SSI States provided the more restrictive policy is not more restrictive than that in your January 1, 1972 plan. Both SSI and §1902(f) States may use a more liberal procedure for institutionalized individuals eligible under a special income level or as medically needy.

**3640.6 Procedures for Submitting Policies Covered by the Moratorium.**--Submit to the Secretary more liberal policies and standards you believe are protected by the moratorium. Policies and standards covering periods prior to the current quarter must be submitted no later than August 31, 1988.

To provide order to the process for determining whether policies and standards are covered by the moratorium and to assure that you are protected under the prescribed moratorium provisions we are using the State plan process ( and the home and community-based waiver process on a very limited basis) as the vehicle to apply moratorium protection even though we do not view provisions covered by the moratorium to be approvable official plan material. Submissions will be handled the same as regular plan or waiver submissions, but amendments containing moratorium protected policies will be disapproved. However, disapproval letters will advise States when there is moratorium protection that no adverse action will be taken during the moratorium period.

Moratorium amendments disapproved because HCFA finds that the policies are not within the scope of the moratorium will be treated as any other disapproval, but the letters of disapproval will contain an explanation as to why the policies are protected.

Although a hearing will be provided on determinations that material fails to qualify for moratorium protection, such determinations are not subject to direct review by the court because the moratorium does not amend title XIX of the Act. The issue of whether a proposed policy conflicts with title XIX is subject to direct review by the court.

If you wish to submit the more liberal moratorium policies and standards that are not included in your current approved plan, make the following annotations to Attachment 2.6-A of your plan or your home and community-based waiver (as appropriate) and submit in the following manner:

A. Attachment 2.6-A.--

1. Income Disregards--Categorically Needy and Medically Needy.--Annotate items C., 1., 1.-d., pages 5-7.

If using more liberal disregards annotate in the margin the appropriate items in the plan to reflect the specific groups affected (i.e., indicate that you are using more liberal disregards under §2373(c) of DRA). The more liberal disregards are reflected on Supplement 5 to Attachment 2.6-A.

2. Resource Exemptions--Categorically Needy and Medically Needy.--Annotate items 5.,a.-d., pages 12 and 13.

If using more liberal resource exemptions annotate in the margin the appropriate items in the plan to reflect the specific groups affected (i.e., indicate that you are using more liberal exemptions under §2373(c) of DRA. The more liberal exemptions are reflected on Supplement 5 to Attachment 2.6-A.

3. Treatment of Income and Resources-Categorically Needy and Medically Needy.--Annotate item 10.,a.-d., page 18.

If using more liberal methods of treating income or resources annotate in the margin the appropriate items in the plan to reflect the specific groups affected (i.e., indicate that you are using more liberal methods under §2373(c) of DRA). The more liberal methods of treating income and resources are reflected on Supplement 5 to Attachment 2.6-A.

B. Supplement 5.--This supplement pertains to more restrictive methodologies §1902(f) States use to determine eligibility of aged, blind and disabled.

Add a page 2 and addendums (as appropriate) to Supplement 5 to reflect more liberal income and resource policies. The new page(s) must clearly indicate that these are proposed moratorium policies and the groups to which they apply. Provide documentation reflecting dates more liberal methods were in effect during periods prior to the current quarter (e.g., dated manual instructions).

C. Home and Community-Based Waivers.--If you wish to use institutional deeming rules for the medically needy, submit waiver and renewal requests using methods approvable under section 1902(a)(10). After the waiver is approved, submit an amendment to the waiver, the single purpose of which is to implement moratorium procedures. The amendment will be subject to regular waiver amendment review procedures.

NOTE: To determine if more liberal methods or standards are protected by the moratorium and the effective date(s) of policy within the moratorium period, you must clearly identify on Supplement 5 exactly to whom policies pertain (e.g. aged, blind, and disabled and/or AFDC-related medically needy, or all persons under the special income level of institutionalized individuals) and the date the policy was effective or is to be effective in the State. If a policy was in effect in a part of the moratorium period that has passed and you wish to reinstate a policy indicate the prior effective dates and the new effective date. Delete from the appropriate Supplement and approved moratorium policies which (during the moratorium period) become policy under §1902(a)(10). Because moratorium policies will be disapproved as part of the official plan, we recommend that you submit moratorium amendments separate from other plan amendments.

3640.7 Resubmission of Current Plan Policies.--Because of changes in eligibility sections of the State plan preprint, some of you have resubmitted old plan preprint pages to protect previously approved policies which are no longer approvable. The practice of including old plan pages among new plan pages has created confusion as the policies States are applying under their plans. Some of the policies contained on the old pages are protected by the moratorium, others are not.

In order to clarify Medicaid plan policies and to assure States maximum protection under the moratorium you must within 3 months of the date of issuance of this instruction:

- o Delete old preprint pages from your plan;
- o Annotate Attachment 2.6-A in the manner described in §3640.5, 1.-3. if you are using financial policies which differ from those required under §1902(a)(10) of the Act;
- o Describe in an addendum to Supplement 5 financial policies included in your current approved plan that differ from those required under §1902(a)(10). Clearly identify that the policies described are included under the current approved plan, to whom the policies apply and the approved effective date of such policies; and
- o Annotate any other pages of the current preprint, as appropriate, to reflect any other approved policies which differ from the Medicaid statute.

Upon submission of the revised plan pages, policies will be reviewed to determine if such policies are within the scope of the moratorium. We will advise you of the status of those policies under the moratorium. Such policies will remain a part of your official plan. However, compliance action may be initiated for policies which do not comply with the Medicaid statute and which are not protected by the moratorium.

**3645. PAY-IN SPENDDOWN OPTION**

Section 4723 of OBRA 1990 (P.L. 101-508) permits you, at your option, to allow individuals, at their option, to spenddown to the medically needy eligibility level through a lump sum payment or installment payments to you. The specific statutory provision establishing this option is contained in §1903(f)(2) of the Act.

A. Before Enactment of OBRA 1990.--Generally, medically needy individuals who must spenddown to meet eligibility standards were required to actually incur expenses to meet their spenddown obligation.

B. After Enactment of OBRA 1990.--With the passage of OBRA 1990, you can now allow individuals to meet spenddown obligations with payments to you, combined with costs incurred in prior months. This is termed the pay-in spenddown option.

**3645.1 Pay-In Spenddown Requirements.**--After you have elected to provide the pay-in spenddown option in your State plan, you must provide all medically needy applicants/recipients with the option of meeting their spenddown liability through use of the pay-in spenddown, or by using incurred expenses under regular spenddown. Advise recipients to consider benefits of using the pay-in option based on anticipated Medicaid covered expenses during the upcoming spenddown period. Then, recipients can decide for themselves whether it is beneficial to use the pay-in option. Use the same income and resource standards for individuals who pay-in as you do for individuals who incur expenses. (See §3623.) Individuals under the pay-in option are subject to the financial determination of eligibility guidelines described in §§3620 and 3620.1.

**NOTE:** 209(b) States that elect the pay-in option must follow Federal pay-in rules and may not use more restrictive rules of their own design.

For comparability, you must use the same budget period for individuals who elect the pay-in option as you use for individuals who incur expenses.

When the budget period is longer than one month, you may allow the individual to pay the pay-in amounts for the full budget period, or in monthly installments.

**3645.2 Application of Expenses Incurred In Prior Months.**--Prior months' incurred expenses that would otherwise be applied toward the individual's spenddown liability must be used with any remaining unmet portion of the spenddown liability representing the amount of pay-in. (Expenses incurred during the 3 months preceding application described in 42 CFR 435.914 are considered prior months' incurred expenses and are deducted from countable income unless such expenses have been paid by or are subject to payment by a legally liable third party as described in §3628.)

**EXAMPLE:** Mr. Jones' spenddown liability is \$600 for the budget period. He has already incurred \$400 in expenses before he elected the pay-in option. Subtracting the \$400 prior incurred expenses from the \$600 leaves Mr. Jones with a \$200 remaining balance as the pay-in amount.

3645.3 Application of Amounts Paid In Toward Spenddown.--The amount paid in by the individual is applied toward reducing the amount of the individual's spenddown liability. It is also used to pay for services received by the recipient during the budget period which are covered and not covered under the State plan. You are not expected to pay for services that are not covered. You must, however, allow use and disbursement of the pay-in amounts for services not covered under the State plan. You may refund unused pay-in amounts (based on the amount that you spent on the individual's behalf) on a case-by-case basis, or you may apply these unused amounts toward any spenddown liability in the next budget period on a case-by-case basis. You may also use both of the options on a case-by-case basis. The decision of which option to use is up to you; not the individual.

3645.4 Federal Financial Participation.--Federal financial participation (FFP) is available only for your expenditures in excess of the amount paid in by the individual. That is, the recipient's spenddown amount must be met prior to services being paid with Medicaid funds, not only for single month spenddown but also for multiple month spenddown periods. (See §3624 for more detailed information on FFP.)

3645.5 State Plan Requirements.--In the State plan, acknowledge the following:

- o Your election of the Medicaid pay-in spenddown option for establishing medically needy eligibility;
- o Your election of the Medicaid pay-in spenddown option in reducing income for establishing categorically needy eligibility; and
- o That you provide individuals the opportunity to elect or reject the pay-in spenddown option on a monthly or quarterly basis.

3645.6 Administrative Requirements.--The following administrative requirements apply:

- o You must provide a written explanation of the pay-in spenddown option to applicant/recipients and you must provide that the election by the applicant/recipient be documented in writing and be retained in the record.
- o You must implement reasonable methods of administering premium collections. For example, you must have a means of accepting cash collections for individuals who do not have checking accounts. In cases of payment by check(s), you are not required to provide services until clearance of the check(s) by the bank.
- o If a refund is made, you must provide individuals with at least yearly statements which advise them of how much they have been charged for services, how much they have paid toward their services, and how much Medicaid has paid for those services.